



Medical Dental History Form

ADULT

Date _____

Case # _____

PATIENT

Patient's Last name _____ First name _____ Middle initial _____

Title Mr. Mrs. Ms. Miss. Dr. Other _____ I prefer to be called _____

Birth date _____ Sex: Male Female Social Security # _____ - _____ - _____

Marital Status Single Married Separated Divorced Widowed

Home address _____ City, State, Zip code _____

Home phone (____) _____ - _____ Cell phone (____) _____ - _____ Work phone (____) _____ - _____

E-mail address(es) _____

Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relatives name(s) _____

Title Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient _____

Address (if different than patient address) _____

Home phone (____) _____ - _____ Cell phone (____) _____ - _____ Work phone (____) _____ - _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe _____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (if different from page 1) _____ City, State, Zip _____

Home phone (_____) _____ - _____ Cell phone (_____) _____ - _____ E-mail address(es) _____

Social Security # _____ - _____ - _____ Employer: _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____

Social Security # _____ - _____ - _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? Yes No Don't know

Secondary policy holder's full name _____ Birthdate _____

Social Security # _____ - _____ - _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? Yes No Don't know

MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____